UTAH APCD

Utah All-Payer Claims Database DATA SUBMISSION GUIDE

REVISION HISTORY

Date	Version	Description	Author
Oct 2013	A	Initial draft	S. Murphy
Oct 2013	B	Changes based on payer comments	D. Arcilesi
Sept 2014	2.1	Incorporated changes approved by HDC	C. Hawley
Sept 2015	2.2	Incorporated changes approved by HDC	C. Hawley
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July 2017	3.1	Proposed Changes	C. Hawley
March 2018	3.1	Correction	C. Hawley

CONTENTS

1.0 DATA SUBMISSION REQUIREMENTS - GENERAL

Data submissions detailed below will include eligibility, medical claims, pharmacy claims, and provider data. Field definitions and other relevant data associated with these submissions are specified in Exhibit A. This specification is based on recommendations from the All Payer Claims Databased (APCD) Council developed in collaboration with stakeholders across the nation.

1.1 DATA TO BE SUBMITTED

1.1.1 MEDICAL CLAIMS

a) Payers shall report health care service paid claims and encounters for all Utah resident members. Payers may be required to identify encounters corresponding to a capitated payment (Exhibit A-2).
b) A Utah resident is defined as any eligible member whose residence is within the State of Utah, and all covered dependents. An exception to this is subscribers covered under a student plan. In this case, any student enrolled in a student plan for a Utah college/university would be considered a Utah resident regardless of their address of record.
c) Payers must provide information to identify the type of service and setting in which the service was provided.
d) Claim data is required for submission for each month during which some action has been taken on that claim (i.e. payment, adjustment or other modification). Any claims that have been "soft" denied (denied for incompleteness, incorrect or other administrative reasons) which the data supplier expects to be resubmitted upon correction, do not have to be submitted until corrections have been completed and the claim paid. It is desirable that payers provide a reference that links the original claim to all subsequent actions associated with that claim (see Exhibit A-2 for specifics).
e) International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and ICD-10, Procedure Coding System (ICD-10-PCS) are required to accurately report patients' risk factors. Healthcare Common Procedural Coding System (HCPCS) and Current Procedural Terminology (CPT) codes are also required.
f) Stand-alone dental carriers should provide contact information to OHCS as required by Utah Administrative Code and submit claims in compliance with this manual.

1.1.2 PHARMACY CLAIMS

a) Payers must provide data for all paid pharmacy claims for prescriptions that were dispensed to members during the reporting period (Exhibit A-3).
b) If your health plan allows for medical coverage without pharmacy (or vice versa), ME018 – ME020 in Exhibit A-1 provides data elements which must accurately represent a member's coverage.

c)

1.1.3 Member Eligibility

a) Payers must provide a data set that contains information on every covered plan member who is a Utah resident (see paragraph 1.1.1.b above) whether or not the member utilized services during the reporting period. The file must include member identifiers, subscriber name and identifier, member relationship to subscriber, residence, age, race, ethnicity, and other required fields to allow retrieval of related information from pharmacy and medical claims data sets (Exhibit A).
b) If dual coverage exists, send coverage of eligible members where payer insurance is primary or tertiary. ME028 is a flag to indicate whether this insurance is primary or tertiary coverage.

1.1.4 Providers

a) Payers must provide a data set that contains information on every health care provider for whom claims were adjudicated during the reporting period.
b) In the event the same health care provider delivered and was reimbursed for services rendered from two different physical locations, then the provider data file shall contain two separate records for that same provider reflecting each of those physical locations. One record shall be provided for each unique physical location for a provider.

1.2 Coordination of Submissions

In the event that the health plan contracts with a pharmacy benefits manager or other service entity that manages claims for Utah residents, the health plan shall be responsible for ensuring that complete and accurate files are submitted to the APCD by the subcontractor. The health plan shall ensure that the member identification information on the subcontractor's file(s) is consistent with the member identification information on the health plan's eligibility, medical claims and dental claims files. The health plan shall include utilization and cost information for all services provided to members under any financial arrangement.

2.0 File Submission Methods

2.1 SFTP

Secure File Transport Protocol involves logging on to the appropriate FTP site and sending or receiving files using the SFTP client.

2.2 Web Upload

This method allows the sending and receiving of files and messages without the installation of additional software. This method requires internet access, a username and password.

3.0 Data Quality Requirements

3.1 Required Elements

The data elements in Exhibit A provide, in addition to field definitions, an indicator regarding data elements that are required. A data element that is required must contain a value unless a waiver is put in place with a specific payer who is unable to provide that data element due to system limitations. A data element marked as "TH" means that a percentage of all records must have a value in this field based on the expected frequency that this data element is available. Data files that do not achieve this threshold percentage for that data element may be rejected or require follow up prior to load into the APCD. A data element marked as "O" is an optional data element that should be provided when available but otherwise may be left blank.

3.2 Validation and Quality Checks

Data validation and quality edits will be developed in collaboration with each payer and refined as test data and production data is brought into the APCD. Data files missing required fields or containing mismatched claim line/record line totals may be rejected on submission. Other data elements will be validated against established ranges as the database is populated and may require manual intervention in order to ensure the data is correct.

The objective is to populate the APCD with quality data and each payer will need to work interactively with the Utah Department of Health (UDOH), Office of Heath Care Statistics (OHCS) to develop data extracts that achieve validation and quality specifications. Waivers may be granted, at the discretion of OHCS, for data variances that cannot be corrected due to systematic issues that require substantial effort to correct.

4.0 File Format

4.1 Standards for Text Files

a) Always one line item per row; No single line item of data may contain carriage return or line feed characters.
b) All rows delimited by the carriage return + line feed character combination.
c) All fields are variable field length, delimited using the pipe character (ASCII=124). It is imperative that no pipes ('|') appear in the data itself. If your data contains pipes, either remove them or discuss using an alternate delimiter character.

d) Text fields are *never* demarcated or enclosed in single or double quotes. Any quotes detected are regarded as a part of the actual data.
e) The first row *always* contains the names of data columns.
f) Unless otherwise stipulated, numbers (e.g. ID numbers, account numbers) do not contain spaces, hyphens or other punctuation marks.
g) Text fields are never padded with leading or trailing spaces or tabs.
h) Numeric fields are never padded with leading or trailing zeros.
i) If a field is not available, or is not applicable, leave it blank. 'Blank' means do not supply any value at all between pipes (including quotes or other characters).

4.2 File Naming Convention

All files submitted to the APCD shall have a naming convention developed to facilitate file management without requiring access to the contents. All files names will follow the template:

UTAPCD_PayerID_TestorProd_EntityAbreviation_SubmisionDate_CoveragePeriodDate.txt

- PayerID – This is the payer ID assigned to each submitter
- TestorProd – Test for test files; Prod for production
- EntityAbbreviation – ME, MC, PC, MP (ME – Medical Enrollment, MC – Medical Claims, PC – Pharmacy Claims, MP – Medical Provider)
- SubmissionDate – Date File was produced. This date should be in the YYYYMMDD format.
- CoveragePeriodDate – The coverage period for the transmission. This date should be in the YYYYMMDD format.

5.0 Data Element Types

date – date data type for dates from 1/1/0001 through 12/31/9999

int – integer (whole number)

decimal/numeric – fixed precision and scale numeric data

char – fixed length non-unicode data with a max of 8,000 characters

varchar – variable length non-unicode data with a maximum of 8,000 characters

text – variable length non-unicode data with a maximum of 2^31 -1 characters

EXHIBIT A - DATA ELEMENTS

A-1 MEMBER ELIGIBILITY FOR CLAIMS DATA

Frequency: Monthly Upload via FTP or Web Portal

It is critical that the member ID (Member Suffix or Sequence Number) is unique to an individual and that this unique identifier in the eligibility file is consistent with the unique identifier in the medical claims/pharmacy claims file.

Additional formatting requirements:

- One record, per member, per month, per insurance type, is required. For example, if a member is covered as both a subscriber and a dependent on two different policies during the same month, two records must be submitted. If a member has two contract numbers for two different coverage types, two member eligibility records must be submitted.
- In order to accurately capture eligibility end dates, payers will submit the previous three months eligibility monthly. This will provide run out to ensure ME005B is populated with a valid last day of eligibility for all members during the previous three months.
- Payers submit data in a single consistent format for each data type.

A-1.1 MEMBER ELIGIBILITY FILE LAYOUT

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
1	ME001	Payer Code	varchar	8	Distributed by OHCS	R
2	ME002	Payer Name	varchar	30	Distributed by OHCS	O
3	ME003	Insurance Type Code/Product	char	2	See Lookup Table B-1.A	R
4	ME004	Year	int	4	4 digit Year for which eligibility is reported in this submission	R
5	ME005	Month	char	2	Month for which eligibility is reported in this submission expressed numerical from 01 to 12.	R
6	ME006	Insured Group or Policy Number	varchar	30	Group or policy number - not the number that uniquely identifies the subscriber Medicaid Fee for Service will populate this field with the Aid Category Code.	R
7	ME007	Coverage Level Code	char	3	Benefit coverage level. See Lookup Table B-1.B	R
8	ME008	Subscriber Social Security Number	varchar	9	Subscriber's Social Security Number; Leave blank if unavailable	TH

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
9	ME009	Plan Specific Contract Number	varchar	128	Plan assigned subscriber's contract number; Leave blank if contract number = subscriber's Social Security Number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the subscriber.	R
10	ME010	Member Suffix or Sequence Number	varchar	128	Unique number of the member. This column is the unique identifying column for membership and related medical and pharmacy claims. Only one record per eligibility month. Must match MC009 and PC009.	R
11	ME011	Member Identification Code	varchar	9	Member's Social Security Number; Leave blank if unavailable.	TH
12	ME012	Individual Relationship Code	char	2	Member's relationship to insured – see Lookup Table B-1.C	R
13	ME013	Member Gender	char	1	M – Male F – Female U - UNKNOWN	R
14	ME014	Member Date of Birth	char	8	YYYYMMDD	R
15	ME015	Member City Name	varchar	30	City location of member	R

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
16	ME016	Member State or Province	char	2	As defined by the US Postal Service	R
17	ME017	Member ZIP Code	varchar	11	ZIP Code of member - may include non-US codes. Do not include dash. Plus 4 optional but desired.	R
18	ME018	Medical Coverage	char	1	Y – YES N - NO 3 - UNKNOWN	R
19	ME019	Prescription Drug Coverage	char	1	Y – YES N - NO 3 - UNKNOWN	R
20	ME020	Dental Coverage	char	1	Y – YES N – NO 3 - UNKNOWN	R
21	ME021	Race 1	varchar	6	See Lookup Table B-1.D	TH
22	ME022	Race 2	varchar	6	See Lookup Table B-1.D	TH
23	ME023	Other Race	varchar	15	List race if MC021or MC022 are coded as R9.	O
24	ME024	Hispanic Indicator	char	1	Y = Patient is Hispanic/Latino/Spanish N = Patient is not Hispanic/Latino/Spanish U = Unknown	TH
25	ME025	Ethnicity 1	varchar	6	See Lookup Table B-1.E	O
26	ME026	Ethnicity 2	varchar	6	See code set for ME025.	O
27	ME027	Other Ethnicity	varchar	20	List ethnicity if MC025 or MC026 are coded as OTHER.	O
28	ME028	Primary Insurance Indicator	char	1	Y – Yes, primary insurance N – No, secondary or tertiary insurance	R

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
29	ME029	Coverage Type	char	3	STN – short-term, non-renewable health insurance (ie COBRA) UND – plans underwritten by the insurer OTH – any other plan. Insurers using this code shall obtain prior approval. AWS – Self-funded	R
30	ME030	Market Category Code	varchar	4	IND – policies sold and issued directly to individuals (non-group) FCH – policies sold and issued directly to individuals on a franchise basis GS3 – policies sold and issued directly to employers having 50 or more employees GSA – policies sold and issued directly to small employers through a qualified association trust OTH – policies sold to other types of entities. Insurers using this market code shall obtain prior approval.	TH
31	ME032	Group Name	varchar	128	Group name or IND for individual policies	O
32	ME043	Member Street Address	varchar	50	Street address of member	R
33	ME044	Employer Name	varchar	50	Name of the Employer, or if same as Group Name, leave blank	O
34	ME101	Subscriber Last Name	varchar	128	The subscriber last name	R
35	ME102	Subscriber First Name	varchar	128	The subscriber first name	R
36	ME103	Subscriber Middle Initial	char	1	The subscriber middle initial	O
37	ME104	Member Last Name	varchar	128	The member last name	R

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
38	ME105	Member First Name	varchar	128	The member first name	R
39	ME897	Plan Effective Date	char	8	YYYYMMDD **Date eligibility started for this <u>member</u>** under this plan type. The purpose of this data element is to maintain eligibility span for each member.	R
40	ME045	Exchange Offering	char	1	Identifies whether or not a policy was purchased through the Utah Health Benefits Exchange (UBHE). Y=Commercial small or non-group QHP purchased through the Exchange N=Commercial small or non-group QHP purchased outside the Exchange U= Not applicable (plan/product is not offered in the commercial small or non-group market)	R
41	ME106	Group Size	char	2	Code indicating Group Size consistent with Utah Insurance Law and Regulation A – 1 B – 2 to 50 C – 51 – 100 D – 100+ Required only for plans sold in the commercial large, small and non-group markets. The following plan/products do not need to report this value: Student plans Medicare supplemental Medicaid-funded plans Stand-alone behavioral health, dental and vision	R

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
42	ME107	Risk Basis	char	1	S – Self-insured F – Fully insured	R
43	ME108	High Deductible/ Health Savings Account Plan	char	1	Y – Plan is High Deductible/HSA eligible N – Plan is not High Deductible/HSA eligible	R
44	ME120	Actuarial Value	decimal	6	Report value as calculated in the most recent version of the HHS Actuarial Value Calculator available at http://cciio.cms.gov/resources/regulations/index.html Size includes decimal point. Required as of January 1, 2014 for small group and non-group (individual) plans sold inside or outside the Exchange.	R - if ME106 = A ME106 = B O - Others

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
45	ME121	Metallic Value	int	1	Metal Level (percentage of Actuarial Value) per federal regulations. Valid values are: 1 – Platinum 2--Gold 3 – Silver 4 – Bronze 5 – Catastrophic 0 – Not Applicable Required as of January 1, 2014 for small group and non-group (individual) plans sold inside or outside the Exchange. Use values provided in the most recent version of the HHS Actuarial Value Calculator available at: http://cciio.cms.gov/resources/regulations/index.html	R - if ME106 = A ME106 = B O - Others
46	ME122	Grandfather Status	char	1	See definition of “grandfathered plans” in HHS rules CFR 147.140 Y= Yes N = No Required as of January 1, 2014 for small group and non-group (individual) plans sold inside or outside the Exchange.	R - if ME106 = A ME106 = B O - Others
47	ME899	Record Type	char	2	Value = ME	R

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
48	ME123	HIOS SCID	char	17	HIOS Standard Component ID with CSR variant e.g. 12345UT0010001-00 where 12345 is the unique Issuer HIOS ID UT is the state code for Utah 0010001 is Issuer defined and indicates a specific plan -00 is the cost sharing variant such that -00 off exchange -01 on exchange -02 zero cost sharing -03 limited cost sharing -04 73% AV Silver -05 87% AV Silver -06 94% AV Silver	R - if ACA Risk Adjustment Plans O - Others
49	ME124	ACA Rating Area	int	1	Geographic rating areas associated with the plan premium. Value = 1, 2, 3, 4, 5, or 6 1 – Cache, Rich 2 – Box Elder, Morgan, Weber 3 – Davis, Salt Lake, Summit, Tooele, Wasatch 4 – Utah 5 – Iron, Washington 6 – Beaver, Carbon, Daggett, Duchesne, Emery, Garfield, Grand, Juab, Kane, Millard, Piute, San Juan, Sanpete, Sevier, Uintah, Wayne	R - if ACA Risk Adjustment Plans O - Others

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
50	ME125	Subscriber Premium	int	10	Monthly subscriber premium, include up to hundredths place, but do not code decimal point (e.g. for $1,123.58 input 112358). Only subscriber records should show a premium amount other than 0. Code as 0 for records where ME012 Individual Relationship Code is not "20 Employee/Self."	R - if ACA Risk Adjustment Plans O - Others
51	ME005A	First day of eligibility in the month	int	2	Day in the month when eligibility began. The first day in the month the member was eligible. Example: a member eligible for the entire month of February will have a value of 1.	R
52	ME005B	Last day of eligibility in the month	int	2	Day in the month when eligibility ends. The last day in the month the member was eligible. Example: a member eligible for the entire month of February will have a value of 28.	R

A-2 MEDICAL CLAIMS DATA

Frequency: Monthly Upload via FTP or Web Portal

Additional formatting requirements:

- Claims are paid claims. Non-covered or denied claims (e.g. duplicate or patient ineligible claims) are not included.
    - It is assumed that a complete snapshot of the claim is submitted at the time of final payment.
    - All claim lines submitted are processed as a unit.
    - Modifications to any previously submitted claim are submitted one of two ways:
        - Reversals - reverse the entire original claim (using MC038) and a new claim may be submitted as a replacement, or
        - Update with new version - replace the original claim with a new version (using MC005A).
        - If a claim reversal is submitted in the same month as the original claim, submission of claims is unnecessary since neither were paid. However, if necessary in the payer system, the version (MC005A) shall be incremented to indicate the reversal (MC038) regardless of method used to modify previously submitted claims.
- Financial amount data elements (MC062-MC067) assume the following:
    - The sum of all claim lines for a given data element will equal the total charge, paid, prepaid, co-pay, coinsurance, or deductible amounts for the entire claim.
    - The paid amount provided for each non-charge financial amount data element is mutually exclusive.
- Payers submit data in a single consistent format for each data type.

A-2.1 MEDICAL CLAIMS FILE LAYOUT

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
53	MC001	Payer Code	varchar	8	Distributed by OHCS	R
54	MC002	Payer Name	varchar	30	Distributed by OHCS	R
55	MC003	Insurance Type/Product Code	char	2	See Lookup Table B-1.A	R
56	MC004	Payer Claim Control Number	varchar	35	Must apply to the entire claim and be unique within the payer's system. No partial claims. Only paid or partially paid claims	R
57	MC005	Line Counter	int	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim. All claims must contain a line 1.	R
58	MC005A	Version Number	int	4	The version number of this claim service line. The original claim will have a version number of 0, with the next version being assigned a 1, and each subsequent version being incremented by 1 for that service line. Plans that cannot increment this column may opt to use YYMM as the version number.	R
59	MC006	Insured Group or Policy Number	varchar	30	Group or policy number - not the number that uniquely identifies the subscriber.	R

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
60	MC007	Subscriber Social Security Number	varchar	9	Subscriber's Social Security Number; Leave blank if unavailable	TH
61	MC008	Plan Specific Contract Number	varchar	128	Plan assigned subscriber's contract number; Leave blank if contract number = subscriber's Social Security Number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the subscriber.	R
62	MC009	Member Suffix or Sequence Number	varchar	128	Unique number of the member within the contract. Must be an identifier that is unique to the member. Must match ME010.	R
63	MC010	Member Identification Code (patient)	varchar	9	Member's Social Security Number; Leave blank if unavailable.	TH
64	MC011	Individual Relationship Code	char	2	Member's relationship to insured – payers will map their available codes to those listed in Lookup Table B-1.B.	R
65	MC012	Member Gender	char	1	M - Male F - Female U - Unknown	R
66	MC013	Member Date of Birth	char	8	YYYYMMDD	R
67	MC014	Member City Name	varchar	30	City name of member	R
68	MC107	Member Street Address	varchar	50	Physical street address of the covered member	TH
69	MC015	Member State or Province	char	2	As defined by the US Postal Service	R

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
70	MC016	Member ZIP Code	varchar	11	ZIP Code of member - may include non-US codes. Plus 4 optional but desired.	R
71	MC017	Date Service Approved/Accounts Payable Date/Actual Paid Date	char	8	YYYYMMDD	R
72	MC018	Admission Date	char	8	YYYYMMDD	R - Institutional Claim
73	MC019	Admission Hour	char	4	Time is expressed in military time - HHMM	R - Institutional Claim
74	MC020	Admission Type	int	1	1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma Center 9 Information not available SOURCE: National Uniform Billing Data Element Specifications	R - Institutional Claim
75	MC021	Admission Source	char	1	SOURCE: National Uniform Billing Data Element Specifications	R - Institutional Claim
76	MC022	Discharge Hour	int	4	Time expressed in military time – HHMM	R - Institutional Claim

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
78	MC023	Discharge Status	char	2	See Lookup Table B-1.F	R - Institutional Claim
79	MC024	Service Provider Number	varchar	30	Payer assigned service provider number. Submit facility for institutional claims; physician or healthcare professional for professional claims. Must match MP001.	R
80	MC025	Service Provider Tax ID Number	varchar	10	Federal taxpayer's identification number	TH
81	MC026	Service National Provider ID	varchar	20	National Provider ID. This data element pertains to the entity or individual directly providing the service.	TH
82	MC027	Service Provider Entity Type Qualifier	char	1	1 Person 2 Non-Person Entity HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a “person”, and these shall be coded as a person.	TH

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
83	MC028	Service Provider First Name	varchar	25	Individual first name. Leave blank if provider is a facility or organization.	TH
84	MC029	Service Provider Middle Name	varchar	25	Individual middle name or initial. Leave blank if provider is a facility or organization.	TH
85	MC030	Service Provider Last Name or Organization Name	varchar	60	Full name of provider organization or last name of individual provider	R

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
86	MC031	Service Provider Suffix	varchar	10	Suffix to individual name. Leave blank if provider is a facility or organization. The service provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III), if applicable, rather than the clinician's degree (e.g., MD, LCSW).	O
87	MC032	Service Provider Specialty	varchar	50	Report the HIPAA-compliant health care provider taxonomy code. Code set is freely available at the National Uniform Claims Committee's web site at http://www.nucc.org/	R
88	MC108	Service Provider Street Address	varchar	50	Physical practice location street address of the provider administering the services	R
89	MC033	Service Provider City Name	varchar	30	Physical practice location city name	R
90	MC034	Service Provider State or Province	char	2	As defined by the US Postal Service	R
91	MC035	Service Provider ZIP Code	varchar	11	ZIP Code of provider - may include non-US codes; do not include dash. Plus 4 optional but desired.	R
92	MC036	Type of Bill – Institutional	char	3	See Lookup Table B-1.G Do not use for professional claims	R - Institutional Claim

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
93	MC037	Facility Type - Professional	char	2	Use CMS Place of Service Codes for Professional Claims ADA Dental Claim Form Completion Instructions requests the same codes for Place of Treatment. Do not use for institutional claims.	R – Professional and Dental Claims
94	MC038	Claim Status	char	2	See Lookup Table B-1.H	R
95	MC039	Admitting Diagnosis	varchar	7	ICD-10-CM. Do not code decimal point.	R - Institutional Claim
96	MC898	ICD-9 / ICD-10 Flag	char	1	0 - This claim contains ICD-9-CM codes 1 - This claim contains ICD-10-CM and ICD-10-PCS codes	R
97	MC040	E-Code	varchar	7	Describes an injury, poisoning or adverse effect. Do not code decimal point.	O
98	MC041	Principal Diagnosis	varchar	7	ICD-10-CM. Do not code decimal point.	R O - Dental Claim
99	MC042	Other Diagnosis – 1	varchar	7	ICD-10-CM. Do not code decimal point.	TH O - Dental Claim
100	MC043	Other Diagnosis – 2	varchar	7	ICD-10-CM. Do not code decimal point.	TH O - Dental Claim

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
101	MC044	Other Diagnosis – 3	varchar	7	ICD-10-CM. Do not code decimal point.	TH O - Dental Claim
102	MC045	Other Diagnosis – 4	varchar	7	ICD-10-CM. Do not code decimal point.	TH O - Dental Claim
103	MC046	Other Diagnosis – 5	varchar	7	ICD-10-CM. Do not code decimal point.	TH O - Dental Claim
104	MC047	Other Diagnosis – 6	varchar	7	ICD-10-CM. Do not code decimal point.	TH O - Dental Claim
105	MC048	Other Diagnosis – 7	varchar	7	ICD-10-CM. Do not code decimal point.	TH O - Dental Claim
106	MC049	Other Diagnosis – 8	varchar	7	ICD-10-CM. Do not code decimal point.	TH O - Dental Claim
107	MC050	Other Diagnosis – 9	varchar	7	ICD-10-CM. Do not code decimal point.	TH O - Dental Claim

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
108	MC051	Other Diagnosis – 10	varchar	7	ICD-10-CM. Do not code decimal point.	TH O - Dental Claim
109	MC052	Other Diagnosis – 11	varchar	7	ICD-10-CM. Do not code decimal point.	TH O - Dental Claim
110	MC053	Other Diagnosis – 12	varchar	7	ICD-10-CM. Do not code decimal point.	TH O - Dental Claim
111	MC054	Revenue Code	char	10	National Uniform Billing Committee Codes. Code using leading zeroes, left justified, and four digits.	R - Institutional Claim
112	MC055	HCPCS/CPT Procedure Code	varchar	10	Healthcare Common Procedural Coding System (HCPCS). This includes the CPT codes maintained by the American Medical Association.	R
113	MC056	Procedure Modifier – 1	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code (MC055).	R
114	MC057	Procedure Modifier – 2	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code (MC055).	R
115	MC058	ICD-10-PCS Procedure Code	char	7	Primary procedure code for this line of service. Do not code decimal point. Leave blank if not an institutional claim.	R - Institutional Claim

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
116	MC059	Date of Service – From	date	8	First date of service for this service line. YYYYMMDD	R
117	MC060	Date of Service – Thru	date	8	Last date of service for this service line. YYYYMMDD	R
118	MC061	Quantity	int	3	Count of services performed.	R
119	MC062	Charge Amount	int	10	Do not code decimal point or provide any punctuation. For example, $1,000.00 converted to 100000. Same format for all financial data that follows.	R
120	MC063	Paid Amount	int	10	Set to zero for capitated claims. Do not code decimal point.	R
121	MC064	Prepaid Amount	int	10	For capitated services, the fee for service equivalent amount. Do not code decimal point.	R
122	MC065	Co-pay Amount	int	10	The preset, fixed dollar amount for which the individual is responsible. Do not code decimal point.	R
123	MC066	Coinsurance Amount	int	10	The dollar amount an individual is responsible for – not the percentage. Do not code decimal point.	R
124	MC067	Deductible Amount	int	10	Do not code decimal point.	R
125	MC068	Patient Account/Control Number	varchar	20	Number assigned by hospital.	O
126	MC069	Discharge Date	date	8	Date patient discharged. YYYYMMDD	R - Institutional Claim

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
127	MC070	Service Provider Country Name	varchar	30	Code US for United States.	R
128	MC071	DRG	varchar	10	Insurers and health care claims processors shall code using the CMS methodology when available. Precedence shall be given to DRGs transmitted from the hospital provider. When the CMS methodology for DRGs is not available, but the DRG system is used, the insurer shall format the DRG and the complexity level within the same field with an "A" prefix, and with a hyphen separating the DRG and the complexity level (e.g. AXXX-XX).	O
129	MC072	DRG Version	char	2	Version number of the grouper used	O
130	MC073	APC	char	4	Insurers and health care claims processors shall code using the CMS methodology when available. Precedence shall be given to APCs transmitted from the health care provider.	O
131	MC074	APC Version	char	2	Version number of the grouper used	O
132	MC075	Drug Code	varchar	11	An NDC code used only when a medication is paid for as part of a medical claim.	O
133	MC076	Billing Provider Number	varchar	30	Payer assigned billing provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change. Must match MP001.	R
134	MC077	Billing Provider NPI	varchar	20	National Provider ID	TH
135	MC078	Billing Provider Last Name or Organization Name	varchar	60	Full name of provider billing organization or last name of individual billing provider.	TH

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
136	MC101	Subscriber Last Name	varchar	128	Subscriber last name	R
137	MC102	Subscriber First Name	varchar	128	Subscriber first name	R
138	MC103	Subscriber Middle Initial	char	1	Subscriber middle initial	O
139	MC104	Member Last Name	varchar	128	Last name of member	R
140	MC105	Member First Name	varchar	128	First name of member	R
141	MC106	Member Middle Initial	char	1	Middle initial of member	O
142	MC201A	Present on Admission – PDX	varchar	1	Code indicating the presence of diagnosis at the time of admission See Lookup Table B-1.I for valid values.	R - if MC041 filled
143	MC201B	Present on Admission – DX1	varchar	1	Code indicating the presence of diagnosis at the time of admission See Lookup Table B-1.I for valid values.	R - if MC042 filled
144	MC201C	Present on Admission – DX2	varchar	1	Code indicating the presence of diagnosis at the time of admission See Lookup Table B-1.I for valid values.	R - if MC043 filled
145	MC201D	Present on Admission – DX3	varchar	1	Code indicating the presence of diagnosis at the time of admission See Lookup Table B-1.I for valid values.	R - if MC044 filled

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
146	MC201E	Present on Admission – DX4	varchar	1	Code indicating the presence of diagnosis at the time of admission See Lookup Table B-1.I for valid values.	R - if MC045 filled
147	MC201F	Present on Admission – DX5	varchar	1	Code indicating the presence of diagnosis at the time of admission See Lookup Table B-1.I for valid values.	R - if MC046 filled
148	MC201G	Present on Admission – DX6	varchar	1	Code indicating the presence of diagnosis at the time of admission See Lookup Table B-1.I for valid values.	R - if MC047 filled
149	MC201H	Present on Admission – DX7	varchar	1	Code indicating the presence of diagnosis at the time of admission See Lookup Table B-1.I for valid values.	R - if MC048 filled
150	MC201I	Present on Admission – DX8	varchar	1	Code indicating the presence of diagnosis at the time of admission See Lookup Table B-1.I for valid values.	R - if MC049 filled
151	MC201J	Present on Admission – DX9	varchar	1	Code indicating the presence of diagnosis at the time of admission See Lookup Table B-1.I for valid values.	R - if MC050 filled
152	MC201K	Present on Admission – DX10	varchar	1	Code indicating the presence of diagnosis at the time of admission See Lookup Table B-1.I for valid values.	R - if MC051 filled

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
153	MC201L	Present on Admission – DX11	varchar	1	Code indicating the presence of diagnosis at the time of admission See Lookup Table B-1.I for valid values.	R - if MC052 filled
154	MC201M	Present on Admission – DX12	varchar	1	Code indicating the presence of diagnosis at the time of admission See Lookup Table B-1.I for valid values.	R - if MC053 filled
155	MC202	Tooth Number	char	2	Tooth Number or Letter Identification. Only include one tooth per claim line. If a procedure was performed on multiple teeth, such as a bridge, include only the first in the span.	R - Dental Claim
156	MC203	Area of Oral Cavity	char	2	Area of Oral Cavity codes are maintained by the American Dental Association	R - Dental Claim
157	MC204	Tooth Surface	char	10	Tooth Surface Identification	R - Dental Claim
158	MC205	ICD-10-PCS Procedure Date	date	8	Date MC058 was performed Leave blank if not an institutional claim.	R – Institutional Claim
159	MC058A	ICD-10-PCS Procedure Code	char	7	Secondary procedure code for this line of service. Do not code decimal point. Leave blank if not an institutional claim.	R – Institutional Claim
160	MC205A	ICD-10-PCS Procedure Date	date	8	Date MC058A was performed Leave blank if not an institutional claim.	R – Institutional Claim
161	MC058B	ICD-10-PCS Procedure Code	char	7	Secondary procedure code for this line of service. Do not code decimal point. Leave blank if not an institutional claim.	R – Institutional Claim

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
162	MC205B	ICD-10-PCS Procedure Date	date	8	Date MC058B was performed Leave blank if not an institutional claim.	R – Institutional Claim
163	MC058C	ICD-10-PCS Procedure Code	char	7	Secondary procedure code for this line of service. Do not code decimal point. Leave blank if not an institutional claim.	R – Institutional Claim
164	MC205C	ICD-10-PCS Procedure Date	date	8	Date MC058C was performed Leave blank if not an institutional claim.	R – Institutional Claim
165	MC058D	ICD-10-PCS Procedure Code	char	7	Secondary procedure code for this line of service. Do not code decimal point. Leave blank if not an institutional claim.	R – Institutional Claim
166	MC205D	ICD-10-PCS Procedure Date	date	8	Date MC058D was performed Leave blank if not an institutional claim.	R – Institutional Claim
167	MC058E	ICD-10-PCS Procedure Code	char	7	Secondary procedure code for this line of service. Do not code decimal point. Leave blank if not an institutional claim.	R – Institutional Claim
168	MC205E	ICD-10-PCS Procedure Date	date	8	Date MC058E was performed Leave blank if not an institutional claim.	R – Institutional Claim
169	MC206	Capitated Service Indicator	char	1	Y – services are paid under a capitated arrangement N – services are not paid under a capitated arrangement U – unknown	R
170	MC899	Record Type	char	2	Value = MC	

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
171	MC061A	Unit of Measure	char	2	Unit of measure for MC061. Valid values are: DA – Days MJ – Minutes UN – Units Other standard ANSI values may be used with prior approval from OHCS.	R
172	MC901	Procedure Modifier – 3	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code (MC055).	R
173	MC902	Procedure Modifier – 4	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code (MC055).	R

A-3 PHARMACY CLAIMS DATA

Frequency: Monthly Upload via FTP or Web Portal

Additional formatting requirements:

- Claims are paid claims. Non-covered or denied claims (e.g. duplicate or patient ineligible claims) are not included.
    - It is assumed that a complete snapshot of the claim is submitted at the time of final payment.
    - All claim lines submitted are processed as a unit.
    - Modifications to any previously submitted claim are submitted one of two ways:
        - Reversals - reverse the entire original claim (using PC025) and a new claim may be submitted as a replacement, or
        - Update with new version - replace the original claim with a new version (using PC201).
        - If a claim reversal is submitted in the same month as the original claim, submission of claims is unnecessary since neither were paid. However, if necessary in the payer system, the version (PC201) shall be incremented to indicate the reversal (MC025) regardless of method used to modify previously submitted claims.
- Financial amount data elements (PC035-PC042) assume the following:
    - The sum of all claim lines for a given data element will equal the total charge, paid, ingredient cost, postage, dispensing fee, co-pay, coinsurance, or deductible amounts for the entire claim.
    - The paid amount provided for each non-charge financial amount data element is mutually exclusive.
- A claim for a compound drug (PC031) should include a claim line for each ingredient in the drug.
- Payers submit data in a single consistent format for each data type.

A-3.1 PHARMACY CLAIMS FILE LAYOUT

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
174	PC001	Payer Code	varchar	8	Distributed by OHCS	R
175	PC002	Payer Name	varchar	30	Distributed by OHCS	R
176	PC003	Insurance Type/Product Code	char	2	See lookup table B-1.A	R
177	PC004	Payer Claim Control Number	varchar	35	Must apply to the entire claim and be unique within the payer's system.	R
178	PC005	Line Counter	int	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim.	R
179	PC006	Insured Group Number	varchar	30	Group or policy number - not the number that uniquely identifies the subscriber	R
180	PC007	Subscriber Social Security Number	varchar	9	Subscriber’s Social Security Number; Leave blank if unavailable	TH
181	PC008	Plan Specific Contract Number	varchar	128	Plan assigned subscriber’s contract number; Leave blank if contract number = subscriber’s Social Security Number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the subscriber.	R
182	PC009	Member Suffix or Sequence Number	varchar	20	Unique number of the member within the contract. Must be an identifier that is unique to the member. Must match ME010.	R

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
183	PC010	Member Identification Code	varchar	128	Member's social security number; Leave blank if contract number = subscriber's Social Security Number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the member.	TH
184	PC011	Individual Relationship Code	char	2	Member's relationship to insured See Lookup Table B-1.C	R
185	PC012	Member Gender	char	1	M – Male F – Female U – UNKNOWN	R
186	PC013	Member Date of Birth	date	8	YYYYMMDD	R
187	PC014	Member City Name of Residence	varchar	50	City name of member	R
188	PC015	Member State or Province	char	2	As defined by the US Postal Service	R
189	PC016	Member ZIP Code	varchar	11	ZIP Code of member - may include non-US codes; Do not include dash. Plus 4 optional but desired.	R
190	PC017	Date Service Approved (AP Date)	date	8	YYYYMMDD – date claim paid if available, otherwise set to Date Prescription Filled	R
191	PC018	Pharmacy Number	varchar	30	Payer assigned pharmacy number. AHFS number is acceptable. Must match MP001.	O
192	PC019	Pharmacy Tax ID Number	varchar	10	Federal taxpayer's identification number coded with no punctuation (carriers that contract with outside PBM's will not have this)	TH

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
193	PC020	Pharmacy Name	varchar	50	Name of pharmacy	R
194	PC021	Pharmacy NPI	varchar	20	Pharmacy's National Provider ID. This data element pertains to the entity or individual directly providing the service.	R
195	PC048	Pharmacy Location Street Address	varchar	30	Street address of pharmacy	TH
196	PC022	Pharmacy Location City	varchar	30	City name of pharmacy - preferably pharmacy location (if mail order leave blank)	R
197	PC023	Pharmacy Location State	char	2	As defined by the US Postal Service (if mail order leave blank)	R
198	PC024	Pharmacy ZIP Code	varchar	10	ZIP Code of pharmacy - may include non-US codes. Do not include dash. Plus 4 optional but desired (if mail order leave blank)	R
199	PC024d	Pharmacy Country Name	varchar	30	Code US for United States	R
200	PC025	Claim Status	char	2	See Lookup Table B-1.H.	O
201	PC026	Drug Code	varchar	11	NDC Code	R
202	PC027	Drug Name	varchar	80	Text name of drug	R
203	PC028	New Prescription or Refill	varchar	2	01 New prescription 02 – 99 Refill Count	R
204	PC029	Generic Drug Indicator	char	2	01 - branded drug 02 - generic drug	R
205	PC030	Dispense as Written Code	char	1	Payers able to map available codes to those below. See Lookup Table B-1.J	R

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
206	PC031	Compound Drug Indicator	char	1	N Non-compound drug Y Compound drug U Non-specified drug compound	O
207	PC032	Date Prescription Filled	date	8	YYYYMMDD	R
208	PC033	Quantity Dispensed	int	5	Number of metric units of medication dispensed	R
209	PC034	Days Supply	int	3	Estimated number of days the prescription will last	O
210	PC035	Charge Amount	int	10	Do not code decimal point or provide any punctuation. For example, $1,000.00 converted to 100000. Same format for all financial data that follows.	R
211	PC036	Paid Amount	int	10	Includes all health plan payments and excludes all member payments. Do not code decimal point.	R
212	PC037	Ingredient Cost/List Price	int	10	Cost of the drug dispensed. Do not code decimal point.	R
213	PC038	Postage Amount Claimed	int	10	Do not code decimal point. Not typically captured.	O
214	PC039	Dispensing Fee	int	10	Do not code decimal point.	R
215	PC040	Co-pay Amount	int	10	The preset, fixed dollar amount for which the individual is responsible. Do not code decimal point.	R
216	PC041	Coinsurance Amount	int	10	The dollar amount an individual is responsible for – not the percentage. Do not code decimal point.	R

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
217	PC042	Deductible Amount	int	10	Do not code decimal point.	R
218	PC043	Unassigned			Reserved for assignment (future use)	O
219	PC044	Prescribing Physician First Name	varchar	25	Physician first name.	R - if PC047 = DEA #
220	PC045	Prescribing Physician Middle Name	varchar	25	Physician middle name or initial.	R - if PC047 = DEA #
221	PC046	Prescribing Physician Last Name	varchar	60	Physician last name.	R
222	PC047	Prescribing Physician NPI	varchar	20	NPI number for prescribing physician	O
223	PC049	Member Street Address	varchar	50	Street address of member	R
224	PC101	Subscriber Last Name	varchar	128	Subscriber Last Name	R
225	PC102	Subscriber First Name	varchar	128	Subscriber First Name	R
226	PC103	Subscriber Middle Initial	char	1	Subscriber Middle Initial	O
227	PC104	Member Last Name	varchar	128	Member Last Name	R
228	PC105	Member First Name	varchar	128	Member First Name	R

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
229	PC106	Member Middle Initial	char	1	Member Middle Initial	O
230	PC201	Version Number	int	4	The version number of this claim service line. The original claim will have a version number of 0, with the next version being assigned a 1, and each subsequent version being incremented by 1 for that service line.	O
231	PC202	Prescription Written Date	date	8	Date Prescription was written	R
232	PC047a	Prescribing Physician Provider ID	varchar	30	Provider ID for the prescribing physician Must match MP001.	R
234	PC047b	Prescribing Physician DEA	varchar	20	DEA number for prescribing physician	O
235	PC899	Record Type	char	2	PC	R
236	PC905	Drug Unit of Measure	varchar	3	Report the code that defines the unit of measure for the drug dispensed in PC033 See Lookup Table B-1.K for valid values.	R

A-4 PROVIDER DATA

Frequency: Monthly Upload via FTP or Web Portal

Additional formatting requirements:

- Payers submit data in a single consistent format for each data type.
- A provider means a health care facility, health care practitioner, health product manufacturer, health product vendor or pharmacy.
- A billing provider means a provider or other entity that submits claims to health care claims processors for health care services directly or provided to a subscriber or member by a service provider.
- A service provider means the provider who directly performed or provided a health care service to a subscriber of member.
- One record submitted for each provider for each unique physical address.

A-4.1 PROVIDER FILE LAYOUT

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
237	MP001	Provider ID	varchar	30	Unique identified for the provider as assigned by the reporting entity Must match MC024, MC076, PC018, or PC047a.	R
238	MP002	Provider Tax ID	varchar	10	Tax ID of the provider. Do not code punctuation.	R
239	MP003	Provider Entity	char	1	F – Facility G – Provider Group I – Independent Practice Association P - Practitioner	R
240	MP004	Provider First Name	varchar	25	Individual first name. Leave blank if provider is a facility or organization.	R
241	MP005	Provider Middle Name or Initial	varchar	25	Provider Middle Name or Initial	O
242	MP006	Provider Last Name or Organization Name	varchar	60	Full name of provider organization or last name of individual provider	R
243	MP007	Provider Suffix	varchar	10	Suffix to individual name. Leave blank if provider is a facility or organization. The service provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III), if applicable, rather than the clinician's degree (e.g., MD, LCSW).	O
244	MP008	Provider Specialty	varchar	50	Report the HIPAA-compliant health care provider taxonomy code. Code set is freely available at the National Uniform Claims Committee's web site at http://www.nucc.org/	R

DSG #	Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
245	MP009	Provider Office Street Address	varchar	50	Physical address – address where provider delivers health care services	R
246	MP010	Provider Office City	varchar	30	Physical address – city where provider delivers health care services	R
247	MP011	Provider Office State	char	2	Physical address – state where provider delivers health care services. As defined by the US Postal Service.	R
248	MP012	Provider Office ZIP	varchar	11	Physical address – ZIP where provider delivers health care services. May include non-US codes; do not include dash. Plus 4 optional but desired.	R
249	MP013	Provider DEA Number	varchar	12	Provider DEA Number	TH
250	MP014	Provider NPI	varchar	20	Provider NPI	TH
251	MP015	Provider State License Number	varchar	20	Prefix with two-character state of licensure with no punctuation. Example UTLL12345	TH
252	MP899	Record Type	char	2	MP	R

B-1 LOOKUP TABLES

B-1.A INSURANCE TYPE

12 Preferred Provider Organization (PPO)
13 Point of Service (POS)
15 Indemnity Insurance
16 Health Maintenance Organization (HMO) Medicare Advantage
17 Dental Maintenance Organization (DMO)
CH Children's Health Insurance Program (CHIP)
CI Commercial Insurance Company
DN Dental
HM Health Maintenance Organization
HN HMO Medicare Risk/ Medicare Part C
MA Medicare Part A
MB Medicare Part B
MC Medicaid Fee For Service (FFS)
MD Medicare Part D
MP Medicare Primary
MO Medicaid Accountable Care Organization (ACO)
QM Qualified Medicare Beneficiary
SP Medicare Supplemental (Medi-gap) plan
TV Title V
99 Other

B-1.B COVERAGE LEVEL CODE

CHD Children Only
DEP Dependents Only
ECH Employee and Children
EPN Employee plus N where N equals the number of other covered dependents
ELF Employee and Life Partner
EMP Employee Only
ESP Employee and Spouse
FAM Family
IND Individual
SPC Spouse and Children
SPO Spouse Only

B-1.C Relationship Codes

01 Spouse
04 Grandfather or Grandmother
05 Grandson or Granddaughter
07 Nephew or Niece
10 Foster Child
15 Ward
17 Stepson or Stepdaughter
19 Child
20 Employee/Self
21 Unknown
22 Handicapped Dependent
23 Sponsored Dependent
24 Dependent of a Minor Dependent
29 Significant Other
32 Mother
33 Father
36 Emancipated Minor
39 Organ Donor
40 Cadaver Donor
41 Injured Plaintiff
43 Child Where Insured Has No Financial Responsibility
53 Life Partner
76 Dependent

B-1.D RACE CODES

R1 American Indian/Alaska Native
R2 Asian
R3 Black/African American
R4 Native Hawaiian or other Pacific Islander
R5 White
R9 Other Race
UNKNOW Unknown/Not Specified

B-1.E ETHNICITY CODES

2182-4 Cuban
2184-0 Dominican
2148-5 Mexican, Mexican American, Chicano
2180-8 Puerto Rican
2161-8 Salvadoran
2155-0 Central American (not otherwise specified)
2165-9 South American (not otherwise specified)
2060-2 African
2058-6 African American
AMERCN American
2028-9 Asian
2029-7 Asian Indian
BRAZIL Brazilian
2033-9 Cambodian
CVERDN Cape Verdean
CARIBI Caribbean Island
2034-7 Chinese
2169-1 Columbian
2108-9 European
2036-2 Filipino
2157-6 Guatemalan
2071-9 Haitian
2158-4 Honduran
2039-6 Japanese
2040-4 Korean
2041-2 Laotian

2118-8 Middle Eastern
PORTUG Portuguese
RUSSIA Russian
EASTEU Eastern European
2047-9 Vietnamese
OTHER Other Ethnicity
UNKNOW Unknown/Not Specified

B-1.F DISCHARGE STATUS

01 Discharged to home or self-care
02 Discharged/transferred to another short term general hospital for inpatient care
03 Discharged/transferred to skilled nursing facility (SNF)
04 Discharged/transferred to nursing facility (NF)
05 Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution
06 Discharged/transferred to home under care of organized home health service organization
07 Left against medical advice or discontinued care
08 Discharged/transferred to home under care of a Home IV provider
09 Admitted as an inpatient to this hospital
20 Expired
30 Still patient or expected to return for outpatient services
40 Expired at home
41 Expired in a medical facility
42 Expired, place unknown
43 Discharged/ transferred to a Federal Hospital
50 Hospice – home
51 Hospice – medical facility
61 Discharged/transferred within this institution to a hospital-based Medicare-approved swing bed
62 Discharged/transferred to an inpatient rehabilitation facility including distinct parts of a hospital
63 Discharged/transferred to a long-term care hospital
64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare

B-1.G TYPE OF BILL

1st Digit - Type of Facility	**2nd Digit - Bill Classification (varies based on 1st Digit)**	**3rd Digit - Frequency**
1 Hospital 2 Skilled Nursing 3 Home Health 4 Christian Science Hospital 5 Christian Science Extended Care 6 Intermediate Care	1 Inpatient (Including Medicare Part A) 2 Inpatient (Medicare Part B Only) 3 Outpatient 4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment) 5 Nursing Facility Level I 6 Nursing Facility Level II 7 Intermediate Care - Level III Nursing Facility 8 Swing Beds	1 admit through discharge 2 interim - first claim 3 interim - continuing claims 4 interim - last claim 5 late charge only 7 replacement of prior claim 8 void/cancel of a prior claim 9 final claim for a home
7 Clinic	1 Rural Health 2 Hospital Based or Independent Renal Dialysis Center 3 Free Standing Outpatient Rehabilitation Facility (ORF) 5 Comprehensive Outpatient Rehabilitation Facilities (CORFs) 6 Community Mental Health Center 9 Other	
8 Special Facility	1 Hospice (Non-Hospital Based) 2 Hospice (Hospital-Based) 3 Ambulatory Surgery Center 4 Free Standing Birthing Center 9 Other	

B-1.H CLAIM STATUS

01 Processed as primary
02 Processed as secondary
03 Processed as tertiary
19 Processed as primary, forwarded to additional payer(s)
20 Processed as secondary, forwarded to additional payer(s)
21 Processed as tertiary, forwarded to additional payer(s)
22 Reversal of previous payment

B-1.I Present On Admission Codes

POA_Code	POA_Desc
3	Unknown
1	Exempt for POA reporting
E	Exempt for POA reporting
N	Diagnosis was not present at time of inpatient admission
U	Documentation insufficient to determine if condition was present at time of inpatient admission
W	Clinically undetermined
Y	Diagnosis was present at time of inpatient admission

B-1.J Dispense as Written Codes

0 Not dispensed as written
1 Physician dispense as written
2 Member dispense as written
3 Pharmacy dispense as written
4 No generic available
5 Brand dispensed as generic
6 Override
7 Substitution not allowed - brand drug mandated by law
8 Substitution allowed - generic drug not available in marketplace
9 Other

B-1.K Drug Unit of Measure

EA Each
F2 International Units
GM Grams
ML Milliliters
MG Milligrams
MEQ Milliequivalent
MM Millimeter
UG Microgram
UU Unit
OT Other